STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175517	A. BUILDING _____ B. WING _____	C 10/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE OVERLAND PARK	12000 LAMAR OVERLAND PARK, KS 66209

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citation represent the findings of complaint investigation #91300.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175517	A. BUILDING _____ B. WING _____	C 10/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE OVERLAND PARK	12000 LAMAR OVERLAND PARK, KS 66209

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 1	F 225		

incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
The facility census totaled 65 residents with 1 resident sampled. Based on record review and interviews, the facility failed to adequately investigate an elopement for 1 of 1 resident (#1).

Findings included:

- The closed record for resident #1 contained an admission Minimum Data Set (MDS) dated 7/29/15 that documented the Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident was cognitively intact. The MDS further documented the resident ' s balance was not steady and only able to stabilize with staff assistance. The resident had a fall prior to admission.

The Medicare 30 day MDS dated 8/19/15 documented the resident ' s balance was not steady but the able to stabilize without staff assistance.

The fall Care Area Assessment dated 8/3/15 documented the resident at risk for falls due to his/her history of falls and weakness following recent surgery.

The 8/5/15 revised care plan documented the resident had impaired cognitive function/dementia (a progressive mental disorder characterized by failing memory and/or confusion) or impaired thought process with the interventions: to explain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175517	A. BUILDING _____ B. WING _____	C 10/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE OVERLAND PARK	12000 LAMAR OVERLAND PARK, KS 66209

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 2	F 225		

care and procedures to the resident prior to beginning and ask yes/no questions in order to determine the resident ' s needs.

The elopement risk assessment dated 7/22/15 documented the resident was a potential elopement risk.

The physician progress notes dated 9/1/15 documented the resident stating he/she needs to " call his/her mother " . The nursing staff reported the resident had similar episodic periods of confusion.

The nurse ' s notes dated 9/4/15 at 7:00 P.M. documented the direct care staff was notified by another family member that a resident was walking alone in the parking lot. The resident was found later walking down the sidewalk and was brought back to the facility. The resident stated he/she was going to his/her house to see his/her mother. The resident was put on frequent monitoring.
During an interview on 9/30/15 at 9:00 A.M. with receptionist S stated she opened the door for this resident as he/she was not in the elopement book, the nursing staff had not notified him/her to not let this resident outside, and the resident did not act confused.

During an interview on 9/30/15 at 12:10 P.M. with therapist T stated he/she left work at 3:06 P.M. on 9/4/15 and drove out of the driveway and saw a resident walking with a walker on the sidewalk. Therapist T turned around, parked the car, went to the resident and called the facility to let them know the resident was outside. Another staff member came outside, down the driveway and to the sidewalk and walked the resident back into

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175517	A. BUILDING _____ B. WING _____	C 10/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE OVERLAND PARK	12000 LAMAR OVERLAND PARK, KS 66209

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 3 the facility. The nursing staff started the resident on 15 minute checks but they were not started until 8:00 P.M. approximately 5 hours after the resident was returned to the facility. The revised March 2008 facility policy " Elopement Risk " documented an elopement occurs when a cognitively impaired resident left the community undetected and unsupervised. The revised 7/2015 facility policy " Incident/Accident Reporting Process " documented the incident report investigation should be reviewed for completion and accuracy of the report and investigation. The facility failed to adequately investigate the incident when this cognitively impaired resident left the facility unattended. The facility failed to initiate the 15 minute checks for this cognitively impaired resident for approximately 5 hours after returned to the facility.	F 225		